ARKANSAS
DEPARTMENT OF HEALTH
PUBLIC HEALTH LABORATORY
201 South Monroe
Little Rock, AR 72205

Influenza Lab Specimen Submission Form

Patient Information (Required fields)**

Patient's Last Name** | First Name** | Middle initial

Address**

City** | State** | Zip** | County of Residence**

DOB(mm/dd/yy)** | Sex** O Male O Female

Race** O White O Black or African American O American Indian/Native Alaska O Asian O Native Hawaiian/Pacific Islander O Other

Ethnicity** O Hispanic O Non-Hispanic O Unknown

Submitter Information (Required fields)**
--------Submitter MUST Provide --------
-----Complete and Accurate Contact Information-----

Submitter ID or #** | Submitter's Name**

Submitter's Address**

City** | State** | Zip**

Phone | **FAX****

Patient Information

Is Patient Pregnant? O Yes O No O Unknown

If Yes, Expected Date of Delivery? _____ /_____ /_____
MM DD YYYY

Health Care Worker? O Yes O No O Unknown

Patient Hospitalized? O Yes O No O Unknown

Vaccinated Against Flu? O Yes O No O Unknown

Recent travel outside U.S.? O Yes O No O Unknown

Was rapid test performed? O Yes O No O Unknown

If Yes, indicate result_____

Patient has underlying medical conditions? O Yes O No O Unknown

Requestor Information (Required)**

Requestor' s Name**

Test / Specimen (Required)**

Test Requested**
O Influenza by PCR

Specimen Type**
O Nasopharyngeal Swab
O Nasal Swab
O Throat Swab
O Nasal Aspirate
O Dual Nasal/Throat Swab

_____ /_____ /_____ Date Collected **
MM DD YYYY

____ : ____ Time Collected**
HH MM

SYMPTOMS (Required)**

Date of Onset**: ___/___/ _____
MM DD YYYY

Symptoms**
☐ Fever > 100 F
☐ Cough
☐ Sore Throat
☐ Other (specify)

_____

Notes: This form is for **PRIVATE** submitters only.
O = Select only ONE; ☐ = Check ALL that apply; ** = Required fields; For times, use Military format HH:MM

PHL 08-69
REV. 08/12/2009